SECTION 7
FORMS

Prior Authorization

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request (yellow form) must be completed and mailed to Verizon Information Technologies,Inc, P.O. Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- The service must be prescribed by a physician or nurse practitioner.
- PA requests are not to be submitted for services prescribed to an ineligible patient. State Consultants review for medical necessity only and do not verify a patient's eligibility.
- Expanded HCY (EPSDT) services are limited to patients under the age of 21 and are **not** reimbursed for patients 21 and over even if prior authorized.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Verizon.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the prior authorization request. All other documentation submitted with the prior authorization request will not be returned. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request. PA requests which are denied must be resubmitted to Verizon with additional documentation as needed. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms. Instructions are also self-contained on the back of the PA request form.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ F U L L ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (8-01) MO 8809

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipients Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipients current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipients address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipients prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening -Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date -The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner-The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

DS1926

Certificate of Medical Necessity

Providers are required to obtain a signed Certificate of Medical Necessity (MN) form for procedures identified in Section 19 of the MO Medicaid Durable Medical Equipment Manual. The following general guidelines apply to all items, services or supplies requiring a MN.

- A MN form must be completed and mailed to Verizon Information Technologies, Inc, P.O. Box 5900, Jefferson City, MO, 65102. Providers should retain a legible copy of the MN form in the patient's record. In the event the first submission of the MN form is denied for additional and/or corrected information, a legible copy may be mailed to Verizon for reconsideration.

- The medical reason why the item, service, or supplies were needed must be stated fully and clearly on the MN form relating to the particular patient involved.

- The item, service, or supply must be prescribed by a physician or nurse practitioner. The original signature of the prescribing individual is required in the "Attending/Prescribing Physician Name" field. An authorized staff member of the DME company who provided the service must sign in the "Provider Signature" field.

- The appropriate modifier must be stated with the HCPCS code on the MN form.

- An approved MN form is valid for six (6) months from the "Date Prescribed". Any claim received matching the criteria, including the modifier, on the MN for that time period can be processed for payment. Additional MN forms must be obtained every six months if the patient's medical need for the service continues.

- Medical consultants and medical review staff review the MN form to make a determination regarding approval of the service. Approval of an MN form does not guarantee payment of claims.

Instructions for completing the Certificate of Medical Necessity form are found in Section 14 of the MO Medicaid Durable Medical Equipment Manual available on the Internet at www.dss.mo.gov/dms.

MISSOURI MEDICAID
CERTIFICATE OF MEDICAL NECESSITY

	Patient Name			Medicaid ID Number	
	TOS	Procedure Codes (Maximum 6)	Description of Item/Service	Reason for Service	Months Equip. Needed (DME only):
1.					
2.					
3.					
4.					
5.					
6.					

Attending/Prescribing Physician Name	Attending/Prescribing Physician Medicaid Number
Date Prescribed / Diagnosis	Prognosis
Provider Name and Address	Provider Medicaid Number
Provider Signature	

MO-8813 PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE REQUIRING DOCUMENTATION OF MEDICAL NECESSITY DS1960 (09/01/02)

Oxygen and Respiratory Equipment Medical Justification

Providers are required to obtain a signed Oxygen and Respiratory Equipment Medical Justification (OREMJ) form for procedures identified in Section 19 of the MO Medicaid Durable Medical Equipment Manual. The following general guidelines apply to all oxygen and respiratory equipment requiring an OREMJ form.

- An OREMJ form must be completed and mailed to Verizon Information Technologies, Inc, P.O. Box 5900, Jefferson City, MO, 65102. Providers should retain a legible copy of the OREMJ in the patient's record. If the initial submission of the OREMJ form is denied for additional and/or corrected information, a legible copy may be mailed to Verizon for reconsideration.

- A new OREMJ form must be completed every 12 months. The patient's attending/prescribing physician must reevaluate the patient at the end of the 12-month period to determine if any change in oxygen dosage or discontinuance of oxygen therapy is appropriate. The attending/prescribing physician who has examined the patient should complete sections B, C, and E as well as signing and dating the form.

- The attending/prescribing physician must have seen the patient, in person, within 30 days prior to the original request for oxygen therapy and within 60 days prior to recertification. These same guidelines apply to testing the patients, i.e., obtaining a new Arterial Blood Gas Study (ABG) or an ear or pulse oximetry.

- The appropriate modifier must be stated with the HCPCS code on the OREMJ form.

- The State Respiratory Consultant reviews the OREMJ forms to determine if oxygen therapy will be approved. A prescription for oxygen that states "Oxygen PRN" or "Oxygen as needed" is not sufficient and will not be approved. Approval of an OREMJ form does not guarantee payment of claims.

Instructions for completing the OREMJ form are found in Section 14 of the MO Medicaid Durable Medical Equipment Manual available on the Internet at www.dss.mo.gov/dms.